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THE COVER

According to the Mother Goose rhyme, "There was an old woman who lived in a shoe. She had so many children, she didn't know what to do. She gave them some broth without any bread, she whipped them all soundly, and sent them to bed." The "children" on the cover, however, are in reality already adults for whom such methods of treatment are no longer of value. During their early childhood, these people failed to receive either enough discipline or love or both, so that emotionally they are still children. Because they do not behave like adults, because they cannot discipline themselves, they fall into conflicts with their environment.

The drawing on the cover is by Mr. Joseph F. Schwarting.

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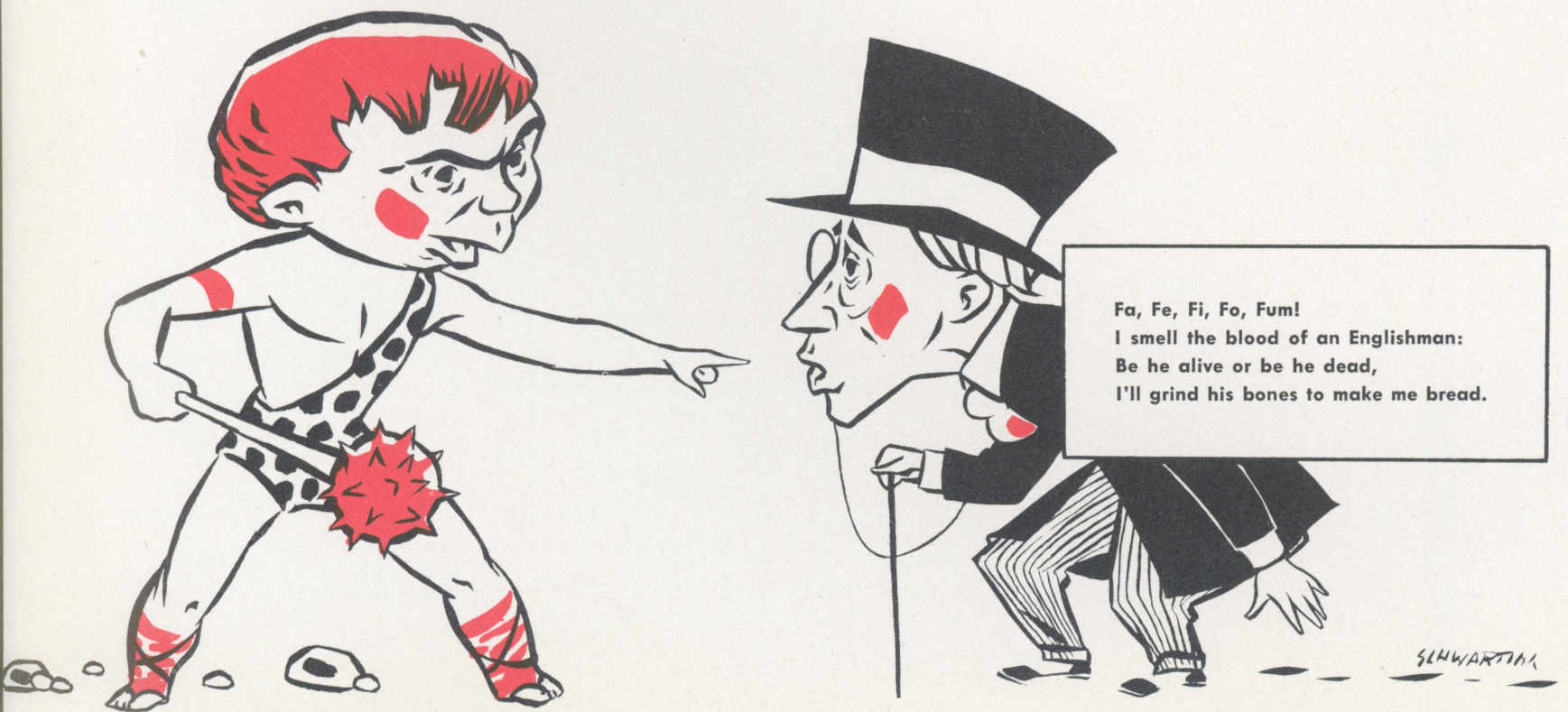
THE PSYCHIATRIC BULLETIN

Contents

IMMATURITY

Rock-a-bye, baby, on the tree top!
When the wind blows the cradle will rock,
When the bough breaks the cradle will fall,
And down will come baby, cradle and all.

Little Polly Flinders sat among the cinders,
Warming her pretty little toes.
Her mother came and caught her,
And whipped her little daughter
For spoiling her nice new clothes.



Fa, Fe, Fi, Fo, Fum!
I smell the blood of an Englishman:
Be he alive or be he dead,
I'll grind his bones to make me bread.

REACTIONS

> Little Boy Blue, come blow your horn!
> The sheep's in the meadow, the cow's in the corn.
> Where's the boy who looks after the sheep?
> He's under the haystack, fast asleep.

IMMATURITY is a word so frequently and glibly tossed about in psychiatric writing that its meaning is often obscure. It is not surprising, therefore, that quite a few physicians have been puzzled to find in the recently revised Standard Nomenclature a group of syndromes labeled Immaturity Reactions. If immaturity of some type or degree is a part of nearly all emotional illnesses, what are the criteria for singling out a special group of reactions under this heading? Furthermore, is there any justifiable reason to add a new set of diagnostic terms to an already complex field?

A noted professor of some years ago used to say that 80 per cent of a physician's stock in trade is prognosis. While this percentage figure might be challenged in these days of antibiotics and surgical miracles, accurate prediction remains a basic tool in the physician's art. Therefore, there is immediate practical value in any refinement of diagnostic classification that furthers understanding of the basic dynamic processes in patients' behavior. On this understanding prognosis depends. In addition, the ultimate goal of rational and effective treatment can only derive from this same understanding.

The immaturity reactions are distinguished from other psychiatric syndromes first of all by the absence or insignificance of *symptoms* in the usual sense (anxiety, phobias, compulsions, pain or other somatic complaints, and the like). There is no psychotic distortion of reality; neither is there any striking asocial, amoral, or criminal behavior such as is shown by the addict, the sexual deviate, or the psychopath. And yet they are people so obviously maladapted in their relations with others that they are often called weak, childish, or hard to get along with. The chief distinguishing characteristic is this: their lives are dominated by the rigid and inflexible repetition of *one* basic pattern in their relationships with those about them that is immature and inappropriate to adult life. *Four* principal patterns comprise the specific diagnostic syndromes: (1) passive-dependent reaction; (2) passive-aggressive reaction; (3) aggressive reaction; and (4) emotional instability reaction.

Passive-dependent reaction

The passive-dependent reaction is characterized by a childlike clinging to others, avoidance of responsibility, indecisiveness, and a proneness to anxiety and ineffectual behavior in situations requiring personal initiative. Many of these individuals succeed in finding someone who wants and needs to protect and dominate them, and so manage a fairly stable adjustment. Women who have this helpless, childlike quality are particularly appealing to some men, and, in our society at least, the female examples of this pattern have a much better chance than do the males. Unfortunately, this "key-in-lock" fitting of reciprocal, immature needs often leads to trouble, since in times of stress the delicate balance may be disturbed. Another drawback is that there are almost always buried resentments toward the dominant person which accumulate under the surface and at times lead to outbursts of infantile temper displays. There is an insatiable need for the approval of someone in authority, quite unlike the adult need for love on a level of equality. Since they dare not risk disapproval, these individuals must wait passively until they are sure what is expected of them; initiative and healthy self-assertion are therefore stifled.

Passive-aggressive reaction

In the passive-aggressive reaction the situation is quite different. These individuals exemplify the Ghandi techniques of rebellion by inaction, stubbornness, procrastination, and passive obstructionism. These are people who, though they have got a little beyond the complete helplessness of infancy, have not quite been able to decide to stand on their own

two feet. They are caught, so to speak, between the desire to be taken care of and the refusal to be dominated. In the narrow dimensions of their emotional world, there is no pattern for relationships except the one of domination-submission—you're either the boss or you do what you're told. Being emotionally unprepared for independence, these people also seek out strong, dominant individuals to lean on, but the course of their relationships is doomed to constant friction because of their thinly veiled and indirectly expressed hostility.

Aggressive reaction

The aggressive reaction type includes the familiar "nobody's going to push me around" attitude. Carrying the proverbial chip on their shoulder, these individuals seem to take every frustration or disappointment in life as a personal affront. Consequently, inappropriate reactions of irritability, temper outbursts, and rages with destructive behavior are frequent. Instead of being afraid to assert themselves, these persons go around asserting themselves all the time in sometimes ludicrous and pathetically irrelevant ways. The conclusion is inescapable that such a person is trying to prove something to himself—that all this chaotic, indiscriminate, rough-shod aggressiveness serves to partially hide a weak, frightened child. Psychiatric study of some of these people would seem to indicate that the all-out resistance against being dominated, conceals an unconscious *wish* to be dominated, to be taken care of as a child. Here the need for approval has often been distorted into a childish *demand* for agreement from others. These individuals do not tolerate differences of opinion very gracefully as a rule. This same *demand for compliance* is extended to the world in general, and underlies the explosive reactions that occur when things do not suit them.

Emotional instability reaction

The last of the four syndromes, the emotional instability reaction, is somewhat less sharply definable. The characteristic pattern of behavior is one of excitability and disorganization under minor stress. This results in inefficiency; unpredictability; and in perplexing and frequently exasperating instability in relationships with other people. The appellation "weak sister" is often applied to such people, and it seems true enough that their tolerance for *normal* anxiety and frustration is extremely low. For this reason it has been particularly tempting to fall back on the concept of a constitutional or inherited "poor nervous endowment" to explain this reaction type. In those that have been carefully studied, however, there is usually good evidence that any existing constitutional defect was given

a generous assist by an unhealthy emotional climate in early childhood.

Etiological factors

With the possible exception of the last-named syndrome, it will be noted that these reactions consist of the *continuation into adult life of emotional patterns appropriate to some phase of childhood.* Every reader who is a parent or a close observer of children will have noted the parallels. In general, one can say that for some reason this is the best level these people have been able to achieve in the long climb from the complete dependence of infancy to the mature give-and-take of adult life. Excessive frustration of or disapproval of the first attempts at self-assertion may cause a child to fall back on and perpetually seek an infantile state of dependence. Someone has said that the passive-dependent person has never accepted being weaned, and goes through life seeking a breast to suckle. The negativistic two-to-three year old, who has discovered he can thwart mother by *not* having his morning bowel movement, as well as by other tactics of literally and figuratively dragging his feet, is a pretty good prototype for the passive-aggressive reaction. And the normal childhood equivalents of the aggressive reaction, such as the "I'll have my way or bust" behavior, are too familiar to need elaboration.

As to the reasons for this arrested emotional development, each individual history is a story all its own. More often than not, the environment during the critical first few years—which usually means the family, principally the parents—fails either to *encourage* or *permit* the step-by-step healthy self-assertion necessary for emotional growth.

Management

One does not often encounter these people as voluntary candidates for psychiatric help. As a group, they have too little awareness of their own emotional problems, and too few painful or unpleasant *symptoms* to feel a need for help. They are more likely to complain that *other people* are always frustrating *them.* As would be expected, when they do come to treatment, they are extremely difficult patients because they bring these same immature attitudes into their relationship with the therapist. Often the best that can be done for such persons is a manipulation of their environment with the idea of avoiding as much as possible the frustration of their immature needs—so far as this does not trespass on the rights of others. Needless to say, a recognition and understanding of the basic emotional pattern allows one to plan such management more intelligently. The family physician, who has the responsibility of general medical care for many people with these immaturity patterns, must understand these patterns if he is to be objective in dealing with them. To be able to see the child in the adult can, in large measure, assuage the physician's disappointment in the management of these difficult patients.

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Case History no. 3012

J. M., a 32-year-old white male, was referred for psychiatric consultation by a general practicing physician who reported that therapy had been unsuccessful, largely because of the patient's failure to cooperate in following instructions for ulcer care. Symptomatic treatment had controlled the ulcer fairly well for three years, but exacerbations of the illness were frequent and often predictable, following episodes of heavy eating or drinking. At the time of referral, the patient had been hospitalized because of a threatened perforation, and both surgical and psychiatric opinion were sought. Surgery was deemed unnecessary because of the rapid improvement in the patient's condition while he was in the hospital for observation. Psychotherapy was recommended and agreed to by the patient, whose recent, serious attack following a drinking bout had made him suspect that he, indeed, might be his own worst enemy.

PERSONAL HISTORY: The patient had been employed as a teller in a small state bank for eight years. His record indicated that he was a meticulous, conscientious worker, highly esteemed by his employers and fellow workers. He was married, and the father of three children, aged eight, six and three. He was making payments on a home, a car, and some electrical appliances, and the monthly installments consumed a large percentage of his income. His mother had resided with the family since the death of his father five years before.

The patient was the youngest of five children, six years younger than his nearest sibling. As a child, he was shy and painfully intimidated by the older children in the family. He reported that he had finished high school but had failed to go to college because his grades had been too poor for admittance to the college of his choice. While attending high school, he had gotten in with a gang of young delinquents and on one occasion he had been arrested after the group had stolen a car. He stated that he had been deceived by the ringleader and left to "take the rap" but that his father had straightened out the matter with the police and no detrimental publicity about the matter had appeared. The episode was recalled with considerable embarrassment, and obvious feelings of guilt and inferiority still prevailed in the young man's mind regarding it.

CURRENT STATUS: The patient reported that lately he had experienced severe epigastric pains almost nightly. These pains usually awakened him following several hours of sleep and persisted for an hour or two, subsiding some time after the ingestion of antacids and milk. When asked if he was aware of any particular worries, he denied that he had anything to worry about.

The therapist inquired whether the patient had ever heard of people who worry without being aware of it. The patient laughed, then looked suddenly startled, and asked if the therapist was kidding. When assured that he was not, the patient admitted that matters in the home were

enough to cause a weaker man considerable anxiety, only he felt sure that he was emotionally firm enough to resist it. The patient was then asked if he wanted to talk about the "things at home."

With some hesitancy the patient stated that there were some disturbances, but they were of such a minor nature he hardly felt them worth reporting—the baby, who had formerly remained dry at night, had started wetting the bed again; his wife always nagged him about having to pinch pennies; whenever his wife made a decision about the rearing of the children, she was inviting an argument with his mother, who had different ideas about child-training. Nothing you could put your finger on, only the patient simply felt that every now and then he had to get away from home, and would spend the evening in a bar, drinking beer. He said he knew that this was stupid, when it only augmented his symptoms. Such an "escape," he stated, had been directly responsible for his recent hospitalization. He had no idea why he did it, under the circumstances. The therapist suggested that perhaps he had some reason for wanting to punish himself.

The patient was silent for a while, then changed the subject. He didn't know why his wife made so much fuss about a three-year-old child who wet the bed. His mother had told her repeatedly that he, himself, was eight years old before she got him cured of it; the child must just have inherited weak kidneys, only Marge couldn't see it that way. He thought she was trying to housebreak the kid to get out of doing the washing.

The therapist pointed out that some physicians think that bed wetting in an older child represents an emotional protest to certain disturbing factors in the environment. This is one way a child can "get even" with parents who treat him unfairly in some way. In a three-year-old, it may not be serious, but in a child of eight. . . that certainly sounded more like protest than weak kidneys. And what might *he* have needed to protest when he was eight years old? The patient stated that frankly, he did not know, but he would give the problem some thought and perhaps he would have some recollections in time for the next interview. The therapist noted that probably there was sufficient material of a disturbing nature in his present situation to warrant worry which could cause periodic flare-ups in his ulcer pains.

During subsequent interviews, the patient's current life situation was carefully studied. It developed that friction between his wife and mother was continuous, although this was kept below the surface. An outward show of respect usually was maintained to mask the hostility felt by both. The patient automatically sided with his mother against his wife, more from habit, it appeared, than from choice. The wife was gradually becoming more and more aloof toward him, until he complained that now she was "almost frigid," a development which distressed him and for which he could offer no satisfactory explanation.

It also became apparent that the patient was bored with his job and dissatisfied with its financial return, yet lacked the self-confidence to do anything about it. Gradually the picture emerged of a timid and apprehensive man, overprotected and infantilized since birth, who felt inadequate in the role of husband, father, and provider for his family.

After six weeks the epigastric pain had receded to approximately once a week, rather than nightly, yet there had been no recognizable change in the patient's life situation.

The fact that he was in therapy was extremely reassuring to this fearful, dependent male. Many times, he tried to force the therapist to make interpretations for him, and to take the responsibility of making minute decisions for him as well. This the therapist absolutely refused to do, but an explanation was given for this behavior. It was suggested that the patient could only profit from the understanding and decisions he managed on his own.

A turning point was reached quite unexpectedly after several months. One day the patient came in for his interview in an obviously agitated frame of mind. His mother, he reported, had been taken suddenly ill several nights before, and he was consumed with fear that she might develop pneumonia. His father had died of pneumonia, he added. Questioning revealed that the mother's illness was minor, consisting only of a superficial chest cold. Why then, did the patient dwell upon the idea of her contracting pneumonia? The patient was shocked and infuriated at the implication of the therapist's question, but his reaction only provoked the further question, "Why are you getting mad?" After a long silence the patient said, "Are you suggesting that I actually *want* her to die?"

"How would it affect your life if she did?" asked the therapist.

The patient buried his head in his hands. Minutes passed before he was able to frame his whispered reply.

"I'd be free."

This was the first time the patient had ever faced his resentment of his mother's lifelong dominion over him. Having repressed it, he had surrounded this resentment with an enormous burden of guilt, to the extent that he complied with his mother's every wish uncritically. This pattern of behavior had stifled his initiative and contributed to an increasing loss of stature in the eyes of his wife.

The attainment of insight regarding this long-hidden conflict enabled him for the first time to view happenings at home on their own merits, rather than from his mother's point of view. After about six weeks, he found that he was able to settle differences either in favor of his wife or his mother, or indeed, to point out that in reality, no differences existed at all. His mother was responsible for several scenes, when she first discovered that she had lost her power over him, but these diminished gradually as he gained in self-reliance and efficiency. He reported that his wife seemed happier and more responsive.

DISPOSITION AND FOLLOW-UP: Psychotherapy was discontinued two months after the patient faced the reality of his mother rejection. A year later, follow-up revealed that he had been promoted to a better job, that his marriage was progressing happily, and that his mother divided her time between his household and those of the other children. While he was not altogether symptom-free, he had had no recurrence of threatened perforation, and he no longer felt the need to spend evenings stirring up his gastric mucosa with alcohol.

ADLER

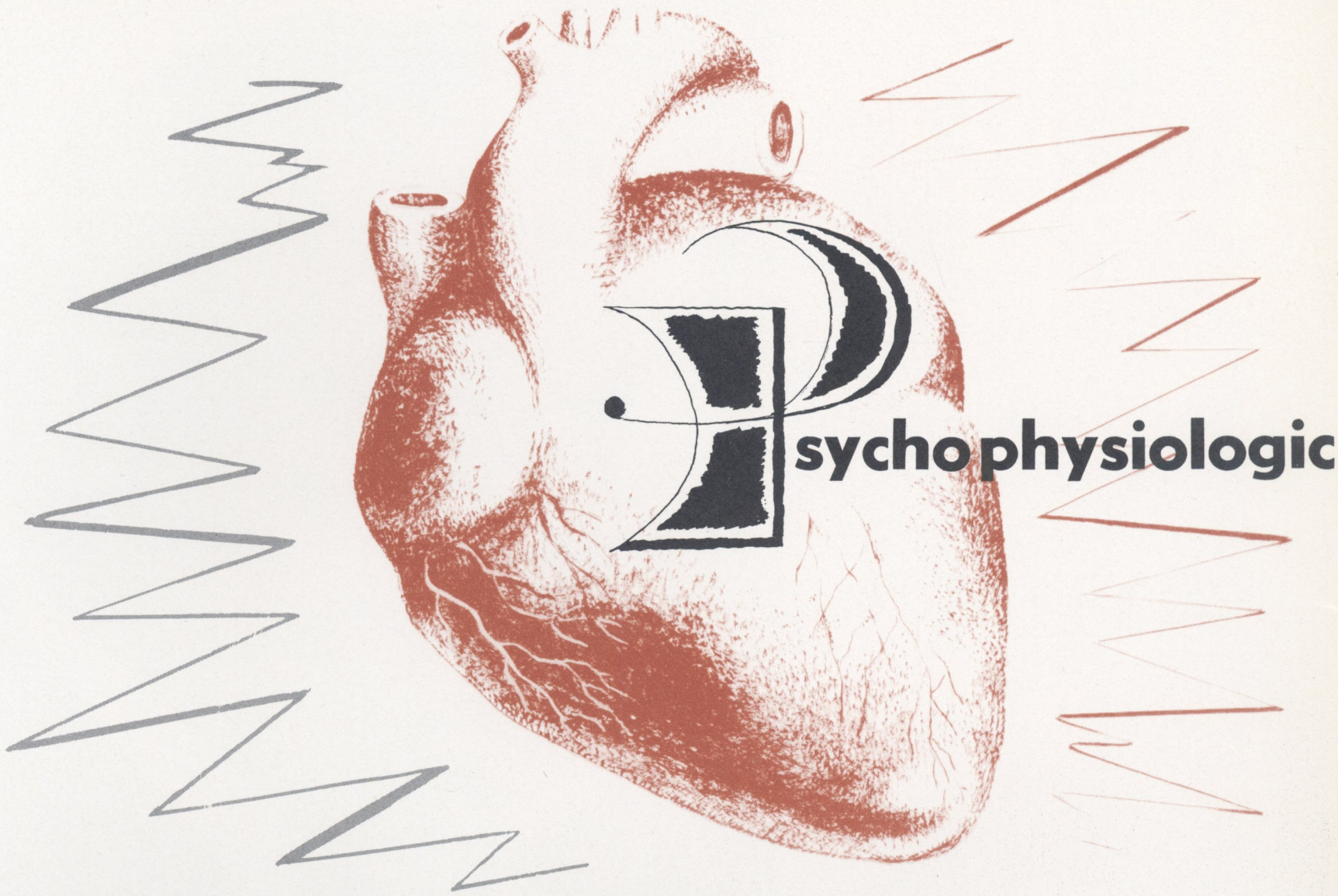
ALFRED ADLER, an early disciple of Freud's, has contributed to psychiatry the concept of man's desire to dominate his environment — as Adler put it, the "will to power." He described man as not only sex-ridden, but power-driven, with the power impulse exceeding even that of sex. He eventually broke with Freud over this difference in emphasis regarding the basic impulsions of man.

Under Adler's theory, man is primarily a social animal. His life process is a struggle for security and dominance. Man becomes power-oriented during childhood, when his very helplessness seems insurmountable and responsible for the many dissatisfactions he encounters in life. If his parental relationships are such as to increase his feelings of weakness and helplessness, the child comes to over-value strength and power. He compensates throughout life by seeking to dominate those about him. There are two methods by which he may achieve this.

He may become openly power-driven, expressing aggressiveness and trying to dominate others, or he may simulate weakness, making insatiable demands for attention, affection and help. Either way, he succeeds in dominating those about him. When carried to an extreme, either of these two orientations to life constitutes a neurosis. Its victim is besieged by pronounced feelings of insecurity and inadequacy. The world is regarded as hostile, and mankind is looked on with suspicion. The capacity for social feeling is weakened and human relationships are understood in terms of struggle, rather than cooperation.

Much human failure comes as a result of impoverished social feeling. There are unavoidable problems of life with which everyone must deal, and social feeling is required to meet them all—work, sex, and contacts of all types with one's fellow-man. According to Adler, the attitude toward one's fellow-man is central, and sexual activity is subordinated to it. In a person who is excessively power-oriented, sexual relations will be established in order to rule the partner, rather than in a spirit of mutual reciprocity. This creates an artificial barrier between the sexes and leads to emotional difficulties in both partners.

The power-driven neurotic will probably not be able to modify his basic attitudes and solve his emotional problems without outside help and guidance. If he consults someone familiar with the Adlerian concept of power, he may come to understand the basis for his need to dominate others, whether it takes the openly aggressive or the passively helpless form. He may then be enabled to exchange his power-orientation for healthier guiding principles, which include recognition of his own personal worth, reciprocity in sexual relations, cooperation with his fellow-man, and responsibility to society.



With the revision of the Standard Nomenclature of Diseases and Operations in 1952, a new category of disorders appeared in the Section on Diseases of the Psychobiological Unit. This new category was listed as "Psychophysiologic, Autonomic, and Visceral Disorders," and under this heading the various manifestations were further identified in accordance with the organ system involved. Thus, the composite term which serves as the title to this article is available for use as a substitute for many different terms which have become increasingly confusing to cardiologists, internists, psychiatrists and physicians in general practice.

DaCosta, in 1871, initiated the confusing terminology by describing psychophysiologic cardiovascular reaction as "irritable heart." During World War I, Sir Thomas Lewis dubbed it "effort syndrome" or "soldier's heart." Other disputed terms which have accumulated through the years include: "cardiac neurosis," "neurasthenia," "neurocirculatory asthenia," and "anxiety neurosis with cardiac manifestations."

When and if the members of the medical profession became accustomed to the new phraseology, the various terms formerly in use may be discarded in favor of the new one. However, long usage of well-known terms may postpone this eventuality; hence, it may be many years before "psychophysiologic cardiovascular reaction" becomes popular as a diagnosis in medical practice. Nevertheless, this is the currently accepted term for disorders of emotional origin which find their expression in morbid symptoms relating to the cardiovascular system.

The psychophysiologic reactions are no longer described as "somatizations" within the group of psychoneurotic reactions, but instead are now listed as a separate group of equal importance. The reason stated for this separation is "to allow more accurate accumulation of data concerning their etiology, course and relation to other mental disorders." It is pointed out that a psychophysiologic reaction is distinguished from a psychoneurotic anxiety reaction in that the neurosis often involves shifting of symptoms from one organ system to another, whereas the psychophysiologic reactions remain confined to a single organ system. Perhaps because of this, there is a tendency for psychophysiologic reactions which originate as "functional" to wind up in structural change which eventually necessitates a change of diagnosis to organic disorder.

There is yet another point which must be made before the discussion of terminology can be fairly abandoned; this deals with nonusage of the popular word, "psychosomatic" in the latest official classification. The Committee on Nomenclature and Statistics for the American Psychiatric Association rejected it as diagnostically unspecific and as implying a dichotomy between mind and body which does not exist.

Although the term "psychosomatic" may represent an oversimplification, it has been useful because it was usable, and doubtless many physicians will continue to use it in preference to a newer and also less

Cardiovascular Reactions

euphonious term. No one will take issue with them, so long as it is understood that it is not merely the mind which works upon the body, but the mutual interplay between psychic and bodily forces which is implied.

Regardless of the fact that the new nomenclature is now entering its third year, cardiologists will probably continue to speak of their "neurocirculatory asthenics," psychiatrists of their "anxiety or cardiac neurotics," and both will be able to arrive at a common understanding in a discussion of functional disorders of the heart.

Diagnosis and therapy

No single factor dominates the etiological picture of psychophysiologic cardiovascular reaction. Indeed, the etiology is obscure.

The physician's first problem is to differentiate between organic disease and psychophysiologic cardiovascular reaction. The history of the patient will frequently provide the first hint of neurosis. For example, the patient's description of a functional precordial pain will usually distinguish it from that of organic pain. Next, the physical examination, including hyperventilation tests for clarification of respiratory syndromes, will yield further evidence of psychophysiologic cardiovascular reaction.

The treatment of choice consists of simple, common-sense psychotherapy augmented with mild sedation when necessary. Actually, therapy begins while the history of the patient is being taken and proceeds along with the physical examination. The attitude of the physician is vitally important, since there are few other conditions in which he can be so easily misunderstood by the anxious patient. Should the physician appear to be unduly concerned, the patient may give way to fears and develop more symptoms. At the other extreme, if the physician tells him his heart is normal and the patient still feels pain, his faith in the physician may be considerably lessened. The patient needs a logical explanation of why he has the pain, and this can be presented as a natural physiological response to some stressful situation of which he may or may not be aware. He is given the reassurance that physical tests reveal no organic damage, following which he needs a reasonable explanation of the way anxiety works on the physiological apparatus. Any physician can put this in simple and understandable terms, citing illustrations of familiar bodily responses to emotional stress. Extra laboratory tests may be ordered with the prediction that they will all be negative; then when they are received, the physician's expectations are confirmed. In this way, the patient is led to understand how the body can be affected by a state of nervous tension.

If medication is prescribed to control symptoms of the emotional tension, the physician should explain its purpose so the patient will not assume he is chronically ill. If emotional conflicts exist and the patient can be persuaded to discuss them, he will often see for himself the connection between stressful events and his cardiovascular attacks; this, combined with the understanding and support of his physician can be most effective in management. The knowledge that his physician accepts him uncritically no matter what his conflicts may be, is one of the strongest factors in helping the patient with functional heart disease to "get it off his chest."

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The National Governors' Conference

● ANY PRESENT-DAY consideration of medical progress is immediately concerned with the more spectacular accomplishments, such as the discovery of the "miracle" drugs. Actually, one of the greatest of modern advances has been in the field of preventive medicine. In clinical medicine the value of prevention has been fully realized, but it has not been, so far, in mental sicknesses. Possibly this is because some of the mental diseases are not fully understood. There is no definite known etiologic agent—no "germ." Psychiatric therapy is predicated upon individual needs, and there is, it frequently seems, nothing learned thereby of general value. Because of a lack of known therapeutic agents, mental hospitals more often offer custodial services rather than remedial ones.

The National Governors' Conference this year was certain evidence of the degree of public concern for the prevention and alleviation of mental illness. At the five previous meetings of the legislators there were discussions of the subject, exchanges of ideas, suggestions for the future; but the 1954 session was significantly different. For the first time, the subject of mental hygiene was the sole subject of the meeting, and, instead of talk, there was concerted action.

Almost 300 persons convened in Detroit on February 8 and 9, and by their attendance attested the national interest in the matter of mental health. Ten states' governors came to discuss possible plans with psychiatrists, mental hospital superintendents, mental health commissioners, and other legislators, from 45 states and Puerto Rico. The results were encouraging and determinate, for the gravity of the need was recognized, as was the responsibility at state and interstate levels. For the first time an explicit program was devised, to which all those present subscribed unequivocally.

This, in abbreviated form, is the ten-point plan, signed by the governors of Minnesota, Kansas, Tennessee, Ohio, West Virginia, Indiana,

New Jersey, Oklahoma, Illinois, and Michigan.

The major share of a state's mental health resources must be used for the care and treatment of patients in state hospitals; therefore, the *fullest use must be made of existing knowledge, and increased appropriations for qualified personnel and intensive treatment programs should be provided.*

This means that therapeutic methods that have proved effective must be made available to more patients. In this connection, many mentally ill patients can be treated on a short-term basis in general hospitals rather than enlarging the problem of custody by relegation to mental institutions. Trained personnel must be concentrated in hospitals and clinics where their skill and knowledge can be most effectively utilized. In addition, some of the personnel shortages can be relieved temporarily by part time employment of workers. For instance, programs in general hospitals that cannot afford the services of a full time psychiatrist or psychiatric social worker can at least employ such persons on a part time basis. Existing church and civic organizations, clubs, and leagues can be utilized for community education programs and discussion groups. Volunteers' services in hospitals, rehabilitation centers, and clinics can be integrated with the mental health program. Many such supplementary possibilities have been tried successfully and are capable of extended usage.

There must be *appropriation of specific sums for training and research in addition to the regular appropriations;* there must be *financial and professional assistance to public and private agencies for preventive programs;* and *a larger percentage of the states' total mental health budget must be allotted for research.* Research funds are inadequate. The amount spent of Federal, state, and agency funds is approximately $12.60 a year for each hospital patient. The proportion of state mental health funds spent for research is estimated at less than one per cent.

Each year mental hospitals admit approximately 250,000 new patients, and of these patients 97.7 per cent are in public hospitals. The cost of the hospitalization alone amounts to $5,000 each for the average patient's hospital stay. The significance of these figures is undeniable, and the individual distress and pain that they connote cannot be computed.

For coordination of mental hygiene training and research, *creation of a directorship and of a technical advisory committee* is recommended.

In order to derive the greatest benefit from the new program, an efficient organization is mandatory to prevent waste or duplication of effort.

Accreditation of state institutions for residency or as training centers should be secured.

One example of the lack of accredited facilities is that of nurses' training. According to the minimum standards set by the American Psychiatric Association, the average state mental hospital is about 66 per cent understaffed in number of registered nurses; but, only 23 of the 1,079 accredited schools of nursing are in mental hospitals.

There must be *provision of stipends for graduate training in psychiatry and related fields, adjustment of salary scales, and provision of leaves of absence.* This is to allow state institutions to compete for the limited available personnel.

The estimated need for state psychiatric hospitals throughout the country is an additional ten to twenty thousand psychiatrists, ten thousand clinical psychologists, and between three and six thousand psychiatric social workers. Most important, such institutions are understaffed in physicians by an estimated 40 per cent, and, in the entire United States, there are only about 12,003 graduate nurses specializing in nervous and mental diseases.

Uniform terminology for statistical reporting procedures should be adopted by all the states.

This uniformity of hospital and clinic statistics is necessary for evaluation of therapy and for comparative studies of procedure. One of the first steps in achieving uniformity is the development of standardized definitions and their use in the statistical bureaus of mental hospitals, as recommended by the United States Public Health Service and the American Psychiatric Association.

Lack of individual state facilities can be compensated by *periodic regional conferences and programs and participation in the Interstate Clearinghouse* established by the Council of State Governors for *joint effort.*

Interaction by groups of states for more effective use of research facilities has already been successful. Such joint effort makes it possible to realize accomplishment of some aspects of the program more quickly.

It is essential that *encouragement and support of mental health education* be given in schools and local organizations.

This final point may be the most significant to the future mental health of this country. Education of the public, extended community psychiatric services, and improved standards of living are positive means of decreasing future incidence of mental illness. One of the first steps of this positive approach is to improve public relations between hospitals and their communities. The isolation of a state hospital is undesirable for the patients, the personnel, and the community. It is wishful thinking to suppose that the modern mental hospital is regarded by the average citizen in the same way as the general hospital. This, then, means that in the public mind psychiatric therapy must be placed in the realm of effective medicine, and public education directed toward cultivation as well as restoration of mental health.

Although the long-term objectives may appear somewhat nebulous in wording, the plan itself is definitive. There is no ambiguity in the immediate need for effective use of available materials nor for procurement of additional funds for research, for trained workers, for increased knowledge to recognize, control, and ultimately to prevent psychiatric illness. What is most encouraging about this program is its practicality.

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MEDICAL WRITING abounds in articles on the doctor-patient relationship and the patient's attitudes toward the physician. However, with the exception of psychiatric literature, the doctor's emotional response to the patient is almost entirely neglected. Exploration of this overlooked half of the relationship reveals that the physician may react to the patient with inappropriate or unwarranted feelings. These result in behavior that is helpful or harmful. Investigation of the origin and manifestation of such feelings will increase the physician's control of his relationships as his self-awareness increases. In exhorting the doctor to treat the patient as a person, the physician himself as a human being has been overlooked. Because of this very necessary quality of being human, it must be assumed that any doctor has, at times, irrational emotional responses to his patients. It is not realistic to believe that he is emotionally dull, that he is incapable of response or so insensitive that he is not curious about himself. Many thoughtful physicians must be aware that they have reactions to their patients which they do not completely understand.

An article on transference in a previous issue of THE PSYCHIATRIC BULLETIN pointed out that certain attitudes and feelings spring up between any two people who have more than the most casual and fleeting relationship. This emotional outgrowth is based on two sources: the response to the real situation between them, and irrational feelings based on emotional experiences of the past which are unconsciously and inappropriately transferred to the present situation. It is this latter portion that is known technically as transference. M. Cohen's operational definition might be paraphrased as follows: when in the patient-doctor

relationship, anxiety is aroused in the doctor with the effect that communication between the two is interfered with by some alteration in the doctor's behavior (verbal or otherwise), countertransference is present.

What importance is the doctor's emotional reaction to a patient? After all, he is reasonably controlled and able to keep how he feels pretty much to himself. But is this really true? The emotional response may have direct bearing on such very practical matters as how many unnecessary night calls he gets from overanxious "Mrs. Jones" who has been allowed to become too dependent on him. It may mean the loss of many desirable patients because the doctor is unable to control his own unwarranted irritation. It may mean irrational feelings of guilt or responsibility when patients respond poorly to treatment or die. It is doubtful that any physician who has been in practice for any length of time could say that "this never happened to me." These, of course, are gross examples of the doctor's behavior; but what of the feelings that give rise to this behavior? Usually they are much more subtle. What are the sources of these feelings?

Disturbing anxiety in the doctor-patient relationship may come from several different sources. It may arise from ideas regarding the nature of the illness, the role of the physician, or the role of the patient. Unresolved problems in the doctor may account for some of it, or communication of the patient's anxiety to the physician may be responsible.

In tracing the development of countertransference in medicine generally, Lewin points out that the medical student's first "patient" is the cadaver which serves as the outlet for not only power drives but also definite feelings of affection. As evidence of the latter, most physicians can recall the nick-names given it, and the general friendly references to it in conversations with their classmates. For these reasons, this completely passive, unresisting object becomes in some ways a student's concept of a patient. Pathology and physiology, by the very nature of their materials, reinforce this idea that the ideal patient is something one may take apart and manipulate as one wishes. When the scalpel is transferred from the corpse to the surgical patient, digitalis from the frog to the cardiac, many students and physicians feel tense and dissatisfied when the latter objects fail to respond as did the original. This tension and dissatisfaction might be formulated as a longing for the original unresisting "patient." Magendie, in his argument with Velpeau on the use of ether, took cognizance of this sublimated wish when he likened the anesthetized patient to a cadaver which could be cut and sliced at will. Certainly all of us have known physicians who could not be much more upset by a speaking, moving corpse than they are by a patient who questions or protests.

The doctor's overevaluation of this ideal patient is counterbalanced by his own experiences of being ill at some time in his life; thus he is able to identify himself as the sick patient. Ill persons are aggressive because the idea of danger is inherent in disease; the physician must apply countermeasures. While these have the rational scientific basis, an unconscious concept of countermagic is inherent in them. This is conscious in primitive people who regard disease as an evil spirit; the medicine man attempts to scare the devil out of the patient while the patient scares the medicine man back. In the case of headaches the doctor slightly poisons the patient with aspirin; but it is easily seen that the more drastic the disease, the more aggressive the magic (treatment).

Placation is another method of dealing with the devil (and the patient); that is, give him what he wants. This philosophy is seen in yielding to a patient's demand for excessive medication or even unnecessary surgery with the rationalization that "if I don't do it some one else will."

But counteraggression brings about guilt. The mere practice of medicine itself is punishing enough to assuage some of this guilt, but another sure-fire technique is the method of history-taking in which the doctor shoves the guilt back on the patient. "When did you last expose yourself to venereal disease? What did you eat that made you sick? How did you fall and break your arm?" Of course, some sensitive patients unconsciously recognize what is being done to them during this procedure and become angry and defensive, completely confounding the physician. This, of course, is a practical example of countertransference—transference in action.

Unresolved neurotic conflicts within the physician are also a source of anxiety. As Rosen points out, a doctor may have no involvement with the patient originally; but the longer he works with the patient the stronger the feelings are, so that the patient eventually comes closer to being like a member of the family. The more he is regarded as a member of the family the more the unconscious conflict which existed in the physician's early life threatens to come to the surface. For example: a physician who had been in conflict with his parents as he grew up was befriended by his grandmother who was very good to him. Later on in practice a similar little old lady came to him for treatment of cardiac

countertransference

disease; he was very interested in and fond of her and made great efforts to help her. Despite all this, however, she eventually began to go downhill and died. With this turn of events the physician experienced profound depression. It was only as he compared his reaction to this patient's death with that of others that he was able to understand that he was reacting not only to her death but also to the earlier death of his grandmother.

Allied to unresolved conflicts is the physician's conception of himself in his role as a doctor. In relation to his patient he may assume the position of domination, of equality, or humble service. A doctor suffering the unconscious conception of himself as a father-God-like figure may tend to be quite dominating in his attitude, have an exaggerated sense of personal integrity and perhaps too much confidence in his technical skill. He seems to think that as long as he is doing his job well, it is really none of the patient's business how this is being accomplished. The doctor who doesn't have such a lofty conception of himself may assume a very fatherly attitude toward the patient; this by implication means that he regards his patients as children. Stokes' example of this is the physician who took care of a young woman with a tuberculous spine, allowing her to become extremely dependent upon him even though she improved. When health threatened to break up their relationship, her emotional attachment grew more prominent and he became protective. However, this was an unworkable situation from which he attempted to withdraw. With that, the patient developed hysterical symptoms, so that the physician was at a loss to decide whether her difficulties were on an organic or emotional basis, and he tended to blame her by implication. She reacted further then by telling untruthful stories about his professional conduct which had a bad effect on his practice. He then became even more anxious and even mistrustful of himself.

If the physician accepts his patients as peers, the patients usually respond favorably to this level of equality. Occasionally, however, a patient becomes extremely agitated and upset when he is accorded this treatment. This may puzzle the physician greatly if he is unaware of factors that work in the patient. Citing Stokes again, a doctor became very angry when a patient became upset, defensive and irritable during the history-taking and physical examination. He was unable to control his own emotion, with the result that the patient became even more upset. Later, in attempting to discover what the patient was reacting to, he learned in reading her chart that her I.Q. was below normal and she did not have the equipment, emotionally or intellectually, to accept a status of equality with the physician.

A physician who approaches his role on the basis of humility engenders in the patient an expectation to perform a technical job while the personal relationship is ignored. This, of course, leaves the doctor without means of assessing the entire situation, frequently causing him to feel frustrated or angry.

From these examples it can be seen that, in general, physicians are not able to maintain an optimum flexible distance from their patients. Instead, they become too close to some, too distant to others, and may even fluctuate from one extreme to the other with the same patient. This inflexibility or fluctuation is a manifestation of countertransference. From the examples given earlier, it is apparent that the doctor may not experience his emotion directly and consciously, but his actions may be governed by responses in a subtle yet effective way. There are other ways that countertransference attitudes manifest themselves.

Specialization may be thought of as one of the most obvious manifestations of countertransference. Fenichel points out that no matter how thoroughly an analyst has been analyzed he works better with some patients than with others. This must be at least part of the explanation for specialization, the doctor feeling that he does better work or is more interested in certain areas than in others. Indeed, one often hears one doctor remark to another that he doesn't see how he can practice his particular specialty day in and day out. The fact that he is able to means that he has personal preference for it, which in turn means that he has some emotional involvement in the specialty and what it symbolizes to him. It is likely that the decision to go into private practice or remain in a teaching or institutional setting is also at least partially determined by unconscious attitudes which manifest themselves in reaction to the patient. Some doctors in an institution seem to have a much more impersonal, cool attitude toward the patient, the institution itself serving to put emotional distance between the doctor and patient.

Hora says that the doctor should continually ask himself: first, how he feels about a patient, then he should attempt to answer this question honestly. Was the feeling appropriate both qualitatively and quantitatively? Negative feelings such as fear, anger, and depression must be resolved or similar responses may be engendered in the patient. Excessive feelings of pride, satisfaction, or power may lead to behavior inappropriate to the real situation between doctor and patient. Cohen says that countertransference is "no more to be feared than is transference; in fact, it cannot be avoided, but can only be looked out for and controlled, and perhaps to some extent removed."

Physicians can learn by observing themselves in these feelings, which help and which hamper their dealings with patients. As the doctor becomes more aware of transference phenomena in the patient, he will become more aware of his own response to it. This conscious insight will help him in solving many psychological problems. On a practical basis it might be well for him to review any disagreeable or very agreeable relationships with patients to determine what is going on with himself and what he has contributed to these situations.

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IN THE YEAR of 600 A.D. all roads led to Rome, and one of the most traveled routes to the Eternal City passed through the province of Antwerp. At the little Belgian village of Gheel one pilgrimage was halted forever. The pilgrimage was that of Dymphna, an Irish princess who, with her confessor and two servants, sought refuge from her insane father. After her mother's death Dymphna had been besieged by her father with demands that she marry him. She secretly became a Christian and escaped to Belgium in the company of a priest, a jester, and the jester's wife. The barbarous king, sparing no means to achieve his wishes, pursued the fugitives and discovered their hiding place at the church of St. Martin. When Dymphna refused to renounce her faith the father ordered them all killed. His henchmen killed the priest; the fate of the jester and his wife is not known; but the king's men refused to strike the young princess. The enraged father then beheaded the girl with his own blade. According to the ancient legend this unnatural crime was accompanied by a sudden miracle. The king, shocked and remorseful at his crime, was restored to sanity and simultaneously converted to Christianity. This was the first of many miraculous cures attributed to the martyred St. Dymphna.

Soon after her death, neighboring villagers began to send their sick to visit Dymphna's tomb. As pilgrims came in increasing numbers to the Flemish countryside a guest house was built and, subsequently, an entire colony formed. Until the last century, persons with all kinds of diseases sought the intercession of the saint, although she was venerated as patroness of the mentally ill.

The first accounts on record of the beatification of St. Dymphna were written in the 13th century, and these relate that she had by that time

long been revered as an especial friend to the mentally deranged. A new church was dedicated to her in 1532, and a fraternity was founded in her name. Stories of cures at her tomb were first published by the Bollandists in the 17th century. Pilgrims continued to live in special cells near the cathedral during this first stage of the historical development of the Gheel system.

The second stage began with the building of a communal hospital within the town, although there was still little attempt at medical therapy. The climate was agreeable and considered beneficial, and a special pilgrimage was made each year to the shrine. On the saint's feast day, May 15, a procession of patients passed through the narrow archway underneath her shrine with prayers for her intercession.

The third period of development, that of state supervision, began in 1858 with the establishment of the Asyl Patronal or headquarters. A more orderly system was inaugurated than that of the Gheelois who had administered the colony until that time. A council of aldermen and a chapter of canons had previously directed the lodging of patients in private homes. After 1858 state physicians assumed administration. The colony was divided into sections, each under the supervision of a physician or alienist, as the specialists in mental illness were called. The foster homes were carefully selected and regularly inspected. Small charges were made to those patients financially able to afford them. A preliminary period of observation was recommended for each patient, after which he was lodged in the colony and given work to do if he were able.

The initial success of the organization at Gheel may be estimated from one report that, after almost 50 years, there had been about 19 per cent recoveries, few fatal accidents, and only one attempt upon life. At the present time the colony provides care for 3,000 patients who live within a 30 mile radius.

Colony systems such as this one were soon attempted in other localities with varying success. Scotland was one of the first countries to try such an arrangement with a cottage system for chronically ill patients. Other establishments were begun in Belgium at Lierneux and then in Germany, Switzerland, and France. D. H. Tuke visited Gheel, as did later advocates of nonrestraint, all of whom cited this successful example. Comparable plans have been tried in Canada and the United States, and a few have survived in modified forms.

The home treatment aspect of the system had advantages that were readily apparent: communal living with no visible regimentation, maintenance of human dignity as a social entity and a part of a family, and the possibility of useful employment. As a result, certain types of psychiatric patients adapted more quickly to this form of care than to that of institutional life. The basic therapeutic principle of nonrestraint is treatment of a mentally ill patient as though he suffered from any common ailment and not as a psychotic person. These patients who worked in the homes, shops and fields and participated in community activity with no apparent restriction were in no way set apart as unnatural, peculiar, or frightening.

Analogous family care programs have been in effect in this country since 1892, although always on a limited scale. At the end of 1947 only six states had placed more than 100 patients in foster homes. During 1952, 24 Veterans Administration Mental Hospitals placed 305 patients in foster homes. Of these, 24 had to be returned to the hospital; 31 were sufficiently well to be transferred to the homes of relatives for trial visits; and 67 were discharged. The major advantages of this project were the release of hospital space, a demonstrable improvement in health of the foster-home patients, and a saving to the taxpayers of approximately 500,000 dollars. The number of patients in family care as of June 30, 1953, in the United States was 6,201.

Presumably, then, community care for selected mental patients remains promising for future investigation. The expense of maintenance would be lessened thereby, and the prospect of a happier and healthier existence offered to the chronically ill. The validity of such an opportunity is attested by the centuries-old plan at Gheel, where the religious shrine to St. Dymphna became the nucleus of a historic program of therapy without restraint.

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Questions and Answers

QUESTION: How can logical man embrace apparently "fantastic" beliefs?

ANSWER: It was Oscar Wilde who said that man could believe the impossible, but never the improbable, and the physician who deals with studies of the mind encounters this paradox repeatedly. Dr. Edmund Bergler, in a recent article, gives one explanation for this seeming discrepancy in human reasoning, through the application of psychiatric teaching. He suggests that things which are merely improbable are judged by the logical forces of the conscious mind, whereas phenomena which are downright impossible are often judged by the yardstick of the infantile unconscious. Psychiatrists know that the unconscious plays a prominent role in influencing the individual throughout his adult life. Thus it is not difficult for them to theorize that the same individual who insisted that Edison's first talking machine was the work of a ventriloquist might at the same time have believed wholeheartedly in witchcraft. Careful study shows that the lore of superstition is replete with references suggesting early fears and infantile megalomania. In psychoanalysis patients discover that they can believe one thing intellectually and yet cannot accept it emotionally. Contrariwise, they can accept a fact emotionally which intelligence tells them is utterly out of the question. The "magical" thinking of childhood may be set aside, but it is never entirely lost, and this has nothing to do with logic. Freud gave an amusing illustration of the way the infantile unconscious "reasons." It is seen in the story of the borrowed pot, which the borrower returned broken. When the owner objected, the borrower said, "First of all, I never borrowed a pot from you; second, I returned it in perfect condition; third, it was already broken when you gave it to me." This type of thinking remains a way of the unconscious throughout life and enables one to accept many beliefs which would doubtless be rejected when viewed from the standpoint of logic alone.

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QUESTION: How reliable is the "lie detector?"

ANSWER: The principle underlying the use of a lie detector implies that a person who employs deliberate deception will simultaneously undergo definite, measurable physiologic reactions. J. A. Larson, working in conjunction with the Berkeley, California, Police Department, developed the first such device in 1921. It was a combination pneumograph and sphygmomanometer which has not been extensively modified to date. There are in the United States today several hundred operators of these devices and great weight is given to their findings, both in civil and criminal judgments. Dr. Douglas Kelley of the School of Criminology, University of California at Berkeley, feels that not only are more effective devices indicated, but there is also a great need for more research into the problem by medical men in the field of biologic psychiatry. What is measured may well be the physiological responses determined by the subject's degree of fear, and fear can be stronger in some individuals who are innocent than in others who are guilty of lying. It is concluded that major research is still to be done in the field of lie detection and this research would best be carried out by medical personnel familiar with psychophysiologic reactions in normal and abnormal people.

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QUESTION: How can psychiatric techniques be best utilized by the internist and general physician?

ANSWER: Since it is conservatively estimated that about 60 per cent of all patients who consult internists and physicians in general practice are suffering from functional illness,

Please turn to page 72

WHY DO PEOPLE D

ONE OF THE MOST frustrating problems confronting physicians working in the cancer field is the patient who detours to nonmedical practitioners. When the detour occurs during the early stages of the disease, it often becomes the deciding factor between control and a fatality.

Who detours to quacks? Why do they detour? What determines the unswerving loyalty of such patients which makes it almost impossible to secure testimony against the quack? What is the key to the success of the nonmedical practitioner? These questions formed the basis for a preliminary investigation of a sample of 20 patients who had detoured to nonmedical sources for treatment when cancer was suspected.

Who detours and when

An analysis of the psychological factors involved in the detouring behavior of this sample indicates that there are four categories of patients who seek nonmedical treatment. There are the miracle seekers, the uninformed, the restless ones, and the straw-graspers. People of these four groups may detour prior to, during, or following orthodox treatment. The stage during which the patient chooses to detour is of utmost importance in light of the urgency for early and adequate treatment.

The miracle seekers and the uninformed

The two groups most likely to seek help from the quack during the preorthodox period of treatment are the miracle seekers and the uninformed. The miracle seeker is the person who is in search of a sure-cure over night. This is the woman who sends for a prayer cloth when she realizes she has cancer of the breast. Just last year one negro woman depended upon her prayer cloth for six months before presenting herself for medical help. She confided that she fully expected each morning to wake to find the fungating mass in her breast gone. In the six months, the disease had progressed to uncontrollable stages. She now is terminal; she still believes that the failure of the prayer cloth was due to her sins. The prayer cloth was much more intelligible to her than the mysterious x-ray machines to which she was subjected during orthodox treatment. Being left alone in a room, strapped to a table, and prey to the fears aroused by the clicking mechanism was an experience of great trauma to her.

The uninformed group was the largest in the sample studied. Although the people with little or no education form the bulk of this group, this is not always the case. For instance, an intelligent man of 42, who had completed high school and a business course, explained his detour as follows: "Well, to tell the truth, I went to a nonmedical practitioner without really knowing what the difference in a M.D. and other people who call themselves doctors is. The only time I remember going to a doctor was when I had my tonsils out. I didn't think too much

about doctors. Someone told me this man was good with cancers, and I went."

Many people unversed in medical areas are unaware of the difference between specialists and clinics specializing in cancer. The daughter of a 78-year-old man, who had been under treatment in a cancer clinic operating without benefit of medical approval, expressed the following idea: "When any of us is sick, we go to a doctor right away. That is the reason when daddy got this skin cancer, we took him to _____Clinic. They specialize in cancer you know, and we didn't want no experimenting on my daddy."

The restless ones

Those seeking help from the quacks during intra-orthodox medical treatment fell completely within the "restless" category in the sample studied. The moot question becomes: what made them restless under medical care? Several psychological factors seem to be operating. One man of 46, who had completed the seventh grade, went to a quack because the physician to whom he had presented himself recommended surgery. He preferred to take his chance with the cancer rather than the surgeon's knife! When some friend recommended a nonmedical practitioner who gave "pills and ointment," he promptly sought his help.

Another man of 53 became impatient during the two-week diagnostic period required for adequate medical workup and laboratory analysis before initiation of treatment. He withdrew from the clinic and went to a quack, who gave him treatment within the hour. Several months later, he returned somewhat shamefaced to confess: "It just took so long to get anything done here, that I got 'antsy.' You know, when you've got cancer, every minute counts. And when you just sit around waiting for two whole weeks, and all they do is examine you once or twice, and then just stick you every day for a blood test . . . well, us people who don't understand why you don't get something done right now, like your home doctor does when you go to him . . . well, we don't know, and we get impatient, and then just plain mad, and do things we wouldn't do, if we understood."

The straw-graspers

Finally, there are the graspers at straws. These are the people the doctors have told, "We have done all we can. There is nothing more medical science can do." Few people can accept such an ultimatum. Many are so constituted that for their own peace of mind, they must continue to try to do something about it.

Often, this group contains people of high intelligence and professional training. An accomplished young oral surgeon explained his detour logically: "The report was malignant melanoma. The final decision was to take off the left arm and shoulder. I thought it over and decided against it . . . I had studied melanoma, and

I knew there was no real hope in that kind of tumor, that there was no adequate control. Surgery was the only hope . . . so, in trying to evaluate my position when my arm and shoulder had to come off, I had to evaluate my family, my profession, and myself. If I consented to surgery, it would mean financial difficulties for the family, and turning to another means of livelihood for me, with all chances against me at my age . . . so looking at it all around, I thought it best to continue as long as I could, get a man partner who could be trained, and who would continue to operate the shop when I was ill, or after I was gone. The family would still have some means of support. This has now been accomplished. Since that time, I have been just marking time. And, well, I heard about this biochemist down in Florida. He was giving pituitary extracts and insulin and a strict diet. I knew he could do me no harm. So I went."

The mother of a three-year-old girl in terminal stages took her to a nonmedical practitioner. She explained: "I just couldn't just sit down and watch her die. The doctors told me they could do nothing more. I kept hearing about this new shot this man was giving and the success he had with it. I just had to try it. For my own peace of mind, I had to know that I had done everything humanly possible to save her."

Why the patient is loyal to the quack

Whether the patient goes to the nonmedical practitioner searching for miracles, grasping at straws, seeking action, or just because he simply does not know the difference between the medical authority and the quack, it is seldom that he will speak disparagingly of the quack. But the patient has no such scruples against voicing his disapproval of the physician. This loyalty to the quack, even in face of failure of treatment, is astonishing.

A 56-year-old woman, with one year of college to her credit, explained her loyalty eloquently: "They was all so courteous to me, I am going to stay with them no matter what else I do. The last doctor I went to was abrupt to me. He said I was in some stage of cancer and the way he said it scared me to death.

Now these _____ people said, 'Look on the bright side and enjoy life all you can.' This doctor took all the joy out of living because he scared me to death. Now with these _____ people, I feel safe and happy. I went to the _____ Clinic because I wasn't getting no satisfaction from my doctors. And well, like I said, I'll stick by them if it is the last thing I do. They helped me more than anybody. I feel better when I take that medicine, and when you start to hurting they give you something for it. They don't say, 'Well, that is just a part of your illness, so we can't help it if you are sick at your stomach.' Or they don't say, 'You just imagine you are hurting.' They give you medicine for anything that ails you."

A lovely young mother of 23, a high school graduate, was approached by a quack-follower while waiting for an appointment in a medical clinic. She verbalized the appeal to her meaningfully: "I get a little nervous sometimes. I really got nervous before I came down here because none of the doctors would hold out any real hope; they just kept saying that they would keep me alive with blood transfusions and then maybe a cure would be found. I don't want to be just kept alive . . . I want to live . . . I want to live normally . . . I want to get well. That is the reason we were pretty tempted by the quacks. They are really interested and seem to want to help so much. And the people who take the treatments are really sold on it. They won't let you take the treatments unless you really have faith in them. You know, sometimes I think maybe it operates sort of like hypnotizing people . . . they sell them so thoroughly. This man I know who is going to a quack . . . everytime he goes up there he comes back all fired up to preach about it for the rest of his life. I know the treatments aren't responsible, but he does actually look and feel better every time he takes one. I know, too, that faith and hope can make you feel better, and sometimes I think that is what they do that perhaps the medical profession doesn't do . . . make you feel completely hopeful and have faith in the treatment you are given."

A business man of 65 somewhat violently expressed his feeling for the quack who had treated him. Learning of his being treated, his daughter called him long distance. He reported his reaction as follows: "I know the medical profession is fighting Mrs._____. I was sitting at her desk when the call came through. My daughter was real mad and demanded that I get right out of there that moment, that the doctor had told her that Mrs._____ was just a 'quack.' It made me plenty

mad, for Mrs._____ had given me more useful information than my daughter's doctor had, and I really told her off."

Still another man who was treated for ten months by a quack, and then came for orthodox care, said that his sister was currently under treatment with the quack. When questioned as to whether he had discussed the failure of the quack to help him with the sister, he responded: "Nope, I thought about it, but I just couldn't do it. I don't want to do them no harm. They was nice to me. I wouldn't want to hurt them none. I know lots of people are agin them, but they was nice to me. They didn't do me no good, but . . . well, I don't think she would listen to me nohow. She's awful sold on them. I don't know, I just can't tell her."

How the quack operates

The psychological techniques of management utilized by the quack make it almost impossible to secure evidence against them. The foregoing excerpts are eloquent reminders of the potency of kindness, consideration, and recognition of the patient as a person. The approach of the quack is a positive one. "I can cure cancer; all I ask is the opportunity to prove it!" This they shout through the press and by word-of-mouth. "I challenge any medical man in the world and prove it beyond the shadow of a doubt that cancer is not hereditary, but that it is infectious." To the miracle seeker, the quack says, "Don't look for a mortician if your doctor diagnoses your illness as cancer. Get a round-trip ticket to _____." To the straw grasper they say, "you have to do your part mentally, physically, spiritually; it is a three-fold process requiring cooperation of yourself, your doctors and your Creator. With this team of workers, you can look forward to a happy life."

To the man grown impatient with the doctor and his medical terminology which has no meaning for him, the quack sounds particularly logical. "Tumors result from the loss of control by the innate intelligence of certain parts and functions of the body," they maintain. "Just as crime often results from the loss of control by parents of the activities and characters of their children." This sort of explanation sounds much more logical to the layman than the medical jargon given him by the physician who does not take time to communicate.

To the practical man who questions, "How can one form of treatment be so beneficial for so many types of ailments?" the answer is simple. "These catalysts have no special affinity for certain types of tissues or form of disease. When injected into the body, they enable the body to produce its own defense mechanism and thus bring about a curative action." When the practical man questions further: "But, how does the same shot cure so many diseases?" the answer is still a ready one. The shot is likened to a starter button on an automobile—once the engine is started, it is not necessary to keep stepping on the starter. So, through simple logic and positive thinking the quack sways many to his support.

To this biased logic and positive approach, the quack then adds the potent ingredient of courteous and gracious treatment as a person at all times. In this way he ties the patient to him through the bonds of grateful appreciation. Finally, when he links his treatment with the Deity, success or failure becomes a part and parcel of the religious faith of the patient. And the quack has placed himself above reproach in the heart of the patient.

The physician can prevent the detour

This brief resume of the psychological factors underlying the "detouring" behavior highlights the importance of the emotional responses of the patients to the physician and to treatment. The medical world has long been aware of the role of improper diagnosis and padded statistics in the success of the quack with cancer. The words of the patients in this sample group emphasize the fact that often they were searching for reassurance, for hope, for recovery, for kindness, consideration, and for communication with the doctor so they might understand what was being done for them when they detoured to the quack. The physician, then, must give proper consideration to the panic psychology which drives a person to the quack when the doctor tells him he has done all that is medically possible, and sends him home to die. The physician must understand the impatience engendered through professional reticence to discuss the disease with the patient. The role of the doctor in prevention of detouring behavior, then, seems to be a dual one. The cancer patient seeks not only adequate medical care, but sympathetic emotional support as well.

● The author reviews the relation of emotional trauma to the precipitation of thyrotoxicosis. He finds unusual similarity in the basic attitudes and personalities of patients studied, and in the defense mechanisms they use to maintain emotional stability.

Emotional trauma, as an etiologic agent in Grave's disease, is consistent with our present knowledge of neurophysiology and endocrinology. The adrenal medulla plays an important role in preparing the body to meet danger and emotional stress. Some experiments suggest that epinephrine stimulates secretion of the thyrotrophic hormone. It is hypothesized that the thyroid contributes to defense against prolonged danger by augmenting short-lived epinephrine effect, keeping the body sensitized to small amounts of the adrenal hormone.

The author's patients fall into three groups: 1. reasonably stable individuals who developed Grave's disease shortly after acute, obvious emotional trauma; 2. seemingly well-adjusted persons undergoing a traumatic incident that did not sound particularly grave, but one which struck at a vulnerable point in their defense, leaving them prey to what they feared most; 3. those individuals who were obviously disturbed in their personality integration and adaptation to life. The third group suffered from severe obsessive and phobic anxiety and substituted extreme degrees of compulsive activity to ward off feelings of isolation and rejection. Failure of these defenses provoked new difficulties and created new anxiety. This group tended to close their eyes to reality, and attempted to continue old unsatisfactory patterns rather than solve their problems.

In the first group, a farmer developed thyrotoxicosis shortly after his wife and baby burned to death despite his efforts to save them.

A case study in the second group is of importance. A 30-year-old negro woman was found to have thyrotoxicosis following hysterectomy. She was very depressed to learn that her uterus had been removed as she wanted a child to take care of her when she was old. It was thought that this was the precipitating emotional insult until review of the chart showed that her thyroid disease began four months prior to surgery. This patient revealed such strong attachment to her father and older brother that her whole life scheme revolved around caring for them. She had not attempted to find a husband for herself, and only needed a child to take care of her in the future to make her security operation complete. She had tried to have a baby out of wedlock. Her brother had married about four months prior to the surgery. The patient was extremely upset about this and dated the onset of her thyrotoxicosis to this particular period of her life.

In the third group a case is reported in which a woman developed hyperthyroidism during a fifth pregnancy which she had been advised against. She magically attempted to deny the pregnancy, and at the same time tried to produce a spontaneous abortion. She had severe religious conflict. In addition, she was so obsessively anxious about her children that she insisted on leaving the hospital to accompany them on a picnic where there might be swimming despite the fact that she herself was terrified of water.

Case histories reveal that a large percentage of the patients are the oldest child in the family; or that death in the immediate family occurred during the patient's early childhood; or that sexual adjustment is poor; or that the patient attaches himself to at least one child with strangling oversolicitude. Basic contradictory attitudes are found: unusual persistent attachment for the mother, premature striving for independence, the need to be dependent, and the need to care for others.

Psychotherapy along with drug therapy is essential to the management of these patients. Relief from the toxic stage is not sufficient, because the patients need help in reorienting and re-establishing their defenses. Psychotherapy may be of particular value in those patients who carry out their medical management poorly, who do not respond to surgery or who relapse after the withdrawal of prolonged medication.

Lidz, T. J.: Emotional Factors in the Etiology and Therapy of Hyperthyroidism, J. Mt. Sinai Hosp. 20:27 (May-June) 1953.

● This study was designed to determine whether the attitudes of mothers of schizophrenics differ significantly from the attitudes of mothers of nonschizophrenics. One hundred mothers of male schizophrenics and a control group of 100 mothers of male nonschizophrenics were studied. They were comparable

QUICKIES

in their age, religion, educational, vocational, socio-economic status, and the age of the son.

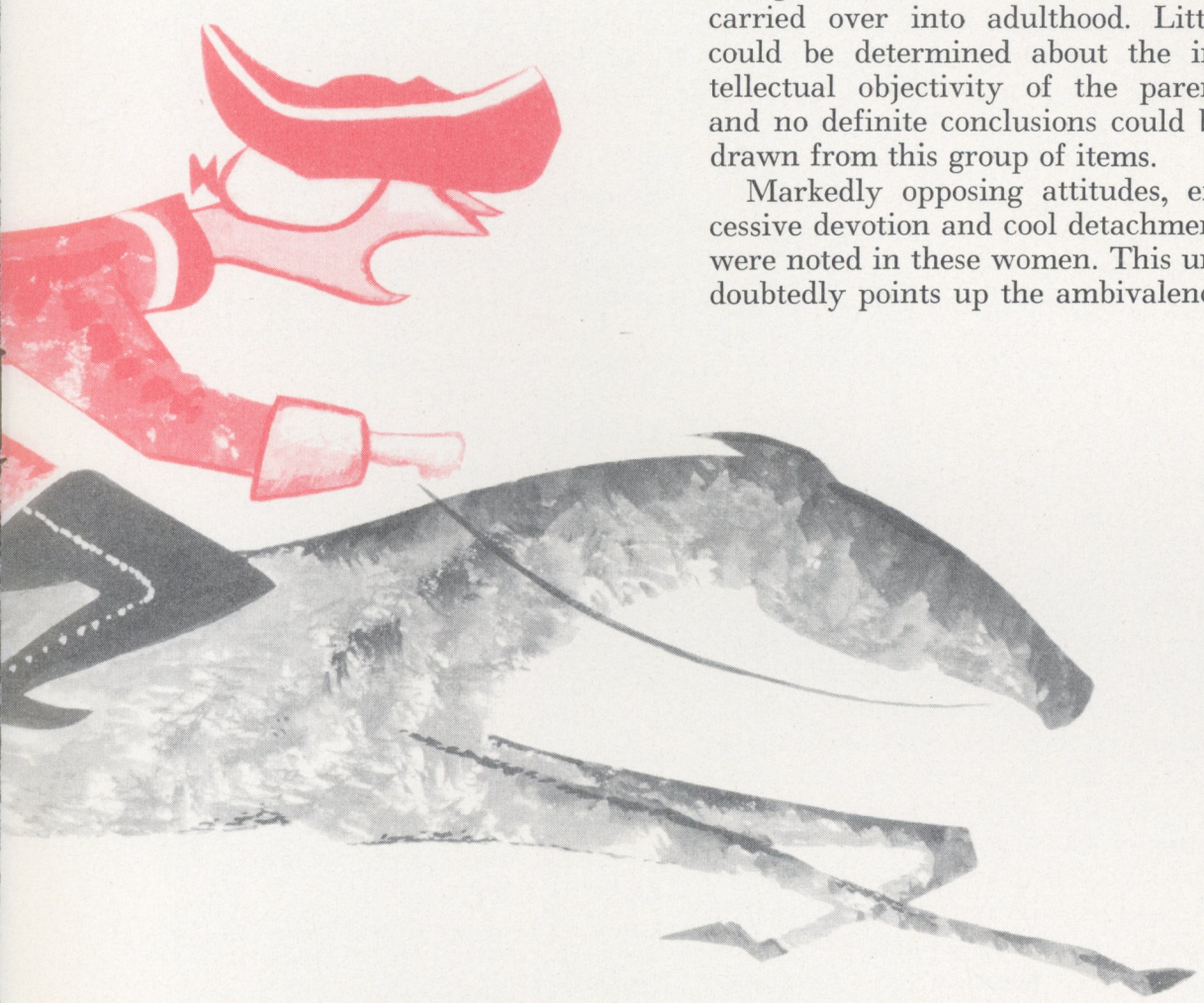
The method of testing was an attitude survey containing 139 items pertaining to child rearing. These items were worded in formal stereotypes such as, "a child should be seen and not heard." The responses were made on a four point scale as agreeing strongly, agreeing mildly, mildly disagreeing, strongly disagreeing. The items for testing fell into three groups: 1. measures of control exerted, from a restrictive-coercive one to a lax, ineffectual one; 2. objectivity of the parent or ability to base her behavior on consciously decided attitudes rather than emotional impulses; 3. the warmth of the parent-child relationship, again allowing for measurements from excessive devotion through marked hostility.

The work of other investigators with regard to personalities of mothers of schizophrenics is cited. Some workers, including Fromm-Reichmann, have felt that the mother may have such an injurious effect upon her child as to cause him to become schizophrenic and has coined the term "Schizophrenogenic mother." Rosen has attempted to establish the origin of schizophrenic patterns in the relation between the mother and the child, particularly feelings of the mother which denote rejection. This study makes no attempt to answer these crucial questions regarding the etiology of schizophrenia. Rather, the author attempts to determine whether or not a characteristic set of attitudes of child rearing is apparent in the mothers of schizophrenics.

From the numerical distribution, it was found that the mothers of schizophrenics were highly restrictive in their attitudes of controlling the children. While some lax and ineffectual attitudes were present, they were far outnumbered by the restrictive ones. These women believed in allowing the children no freedom of choice or activity and in carefully prescribing and channeling behavior. These mothers frowned on friends and sex-play, tended to keep sexual information from the children, yet felt that it was their duty to know everything the children thought. This restrictive attitude carried over into adulthood. Little could be determined about the intellectual objectivity of the parent and no definite conclusions could be drawn from this group of items.

Markedly opposing attitudes, excessive devotion and cool detachment were noted in these women. This undoubtedly points up the ambivalence of their feelings toward their children. The author believes that this is a valuable study, but that it should be duplicated in larger populations in order to validate his tentative conclusions.

Mark, J. C.: The Attitudes of Mothers of Male Schizophrenics Toward Child Behavior, J. Abnorm. & Social Psychol. 48:2 (April) 1953.



● Psychological problems can result in obesity, can interfere with its treatment, or can be caused by obesity. In contrast with the group of people who gain weight according to their constitutional make-up is another group in whom overweight results from compulsive eating which represents an expression of emotional maladjustment. The author points out the difference in the way these two groups approach the reducing process. The fairly well-adjusted fat person wants to lose weight for realistic reasons of health and looks. For the other group, weight loss is the key to successful fulfillment of fantastic hopes and daydreams.

The author's work with the latter group reveals several psychological problems which can lead to obesity: a badly distorted sense of reality, a compulsion to be bigger and better than anybody else, or to fulfill frustrated ambitions and yearnings. The above problems lead to misinterpretations of the individual's importance in the world and to feelings of inadequacy. The conflict between impossible aspirations and driving ambitions creates tension, dissatisfaction, and despair. Overeating often results from primitive beliefs that eating makes up for the defects, and increase in size fulfills a primitive symbolic level of the desire to be big. However, the patient thus brings about secondary disgust and self-hatred, as well as feelings of guilt for being weak and greedy. Success and greatness then are often equated with the condition of being thin.

For some overweight children, dieting becomes the focus of family arguments so that they become defiantly resistant to the very word itself. Often they feel that they are looked upon only as a body instead of a real person and this increases their bitterness and self-defeating negativism. Staying fat may also be a plea for continuous love, the idea

being that anyone who really cared would love him, fat or thin.

The author stresses the importance of the conflict in the desire to be thin and yet retain magical power that being fat implies. This may be so intense that the patient feels "in danger" as he diets.

Excess weight, however damaging and undesirable, must be thought of as a symptom which serves an important function in a precarious adjustment to life. Dieting should not be attempted until this adjustment is better stabilized. Persistence of obesity may be a protection against a serious mental breakdown, even of a psychosis. The author feels that the problem should be one of "treating fat people and their problems of living, rather than mainly an attack on symptoms." Impatient parents often demand that their obese child lose weight immediately, unaware of the psychological readjustments that must be accomplished in order to make weight loss healthy from both the physical and the mental point of view. Anyone treating these patients should keep in mind the need for a realistic appraisal of the level of ambition and aspiration. Only when a person pursues goals which have possibilities of realistic fulfillment is he able to renounce his overeating and large size, and enter a reducing process with any prospect of success.

Bruch, H. J.: The Psychosomatic Aspects of Obesity, J. Mt. Sinai Hosp. 20:1 (May-June) 1953.



QUESTIONS AND ANSWERS

Continued from page 65

all of the psychotherapeutic measures should be of more than casual interest to medical men in these particular fields. Certain techniques, particularly, may prove surprisingly effective in spite of their apparent simplicity of application. When a physician has cause to suspect that a patient's symptoms are predominantly emotional in origin, it may be rewarding to postpone the accumulation of routine historical data in favor of what psychiatrists call "ventilation," or letting the patient talk freely about his personal situation. This is not, however, a passive endeavor on the part of the physician, for it is up to him to guide the conversation first to the subject of what the patient's emotions were at the onset of symptoms and what life situations prevailed whenever the symptoms became worse. The physician further guides the interview by echoing something the patient has said whenever the interview tends to bog down. This sounds disarmingly simple, and yet its uses are apparent; the patient is reassured that the physician is giving his attention, he feels called upon to clarify what he has said, and in attempting to clarify himself, the patient frequently comes up with an entirely new statement, more illuminating than anything which has gone before. This is not, in any sense, "idle listening." It can be immensely productive, so much so that the technique has been dignified with the official term, "associative anamnesis." Dr. Feliz Deutsch is credited with originating it, and others have modified the system in accordance with their own requirements. The internist and the physician in general practice may find that psychotherapy for many patients may be considerably shortened by accumulating pertinent material in this manner and then assembling the data on several patients for discussion in regular consultations with a psychiatrist, who may offer beneficial advice about how best to utilize the information. In this way, much practical help may be gained in dealing effectively with functional symptoms.

Reference: Harris, H. I., and Peters, C. M.: The Treatment of Psychosomatic Disorders by the Internist, Am. Pract. 5:158 (March) 1954.

QUESTION: What are the indications for psychiatric referral in hypochondriasis?

ANSWER: In a recent series of articles, Dr. Henry P. Laughlin discusses the different conditions in which hypochondriacal preoccupation is most frequently encountered, presents a series of ten case histories, and emphasizes the diagnostic and therapeutic difficulties involved in patients with hypochondriacal trends. It is one psychiatric condition which is least likely to respond to simple reassurance, because most patients suffering from somatic preoccupation have been laughed at by family and friends, and even told by some physicians to "snap out of it" since there is nothing wrong with them. This information does nothing to alleviate the bodily discomforts they feel. Patients who harbor undue somatic preoccupation do so for certain definite reasons, among which are: regression to an earlier, dependent phase of living; punishment for guilt feelings; the attainment of sympathy and attention; and the escape from an intolerable situation. The physician who would understand hypochondriasis will first concern himself with the question: "what purpose is this behavior serving the patient?" Dr. Laughlin indicates five conditions in which psychiatric assistance is indicated for the hypochondriacal patient:

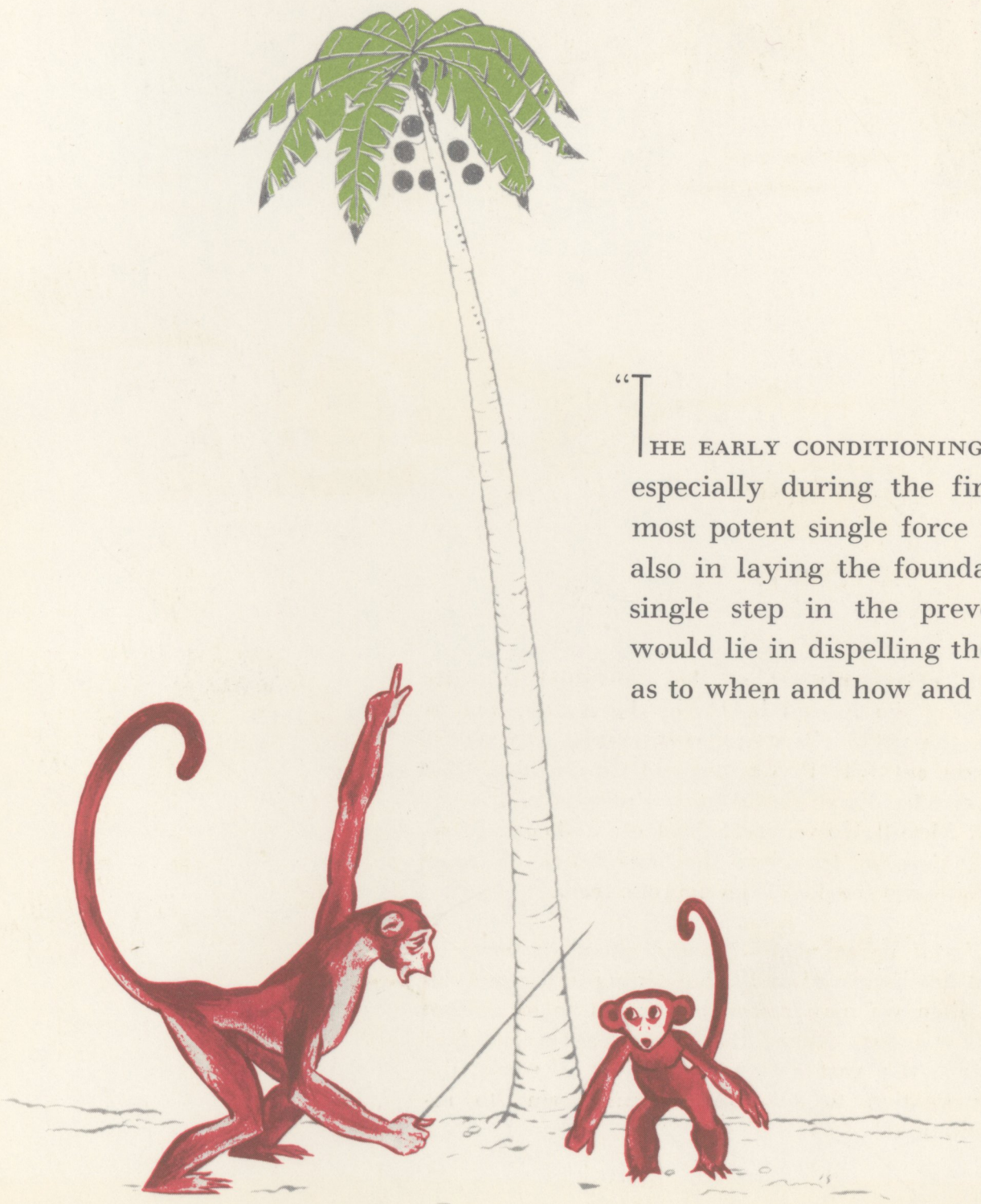
1. When the preoccupation is excessive in degree.
2. When there is a large discrepancy between organic status and the bodily concern.
3. When the preoccupation appears progressive.
4. When it is suspected that the hypochondriacal trends represent a psychosis and the defenses are beginning to break down.
5. When the hypochondriasis is so disabling that it interferes with normal living.

Reference: Laughlin, H. P.: Overconcern with Health, M. Ann. District of Columbia 23:147 (March) 1954.

An Individual's Responsibility

THE RESPONSIBILITY of the individual in safeguarding the mental health of the nation, and in turn, the world of nations, was stressed in a recent address entitled "Psychiatry and Citizenship." The speaker, Dr. Ewen Cameron, is Professor of Psychiatry, McGill University School of Medicine, Montreal, Canada. He cited the importance of inner strength and freedom from neurotic fears:

"For if behavior can be understood in terms of what has happened and is happening to the individual, then we may reasonably expect to be able to modify action. Hence the great changes in child rearing, the vast expansions of social work, the determination to subordinate punishment to rehabilitation."



"THE EARLY CONDITIONING, up through the fifth year but especially during the first three years, is perhaps the most potent single force in shaping the personality, but also in laying the foundation for neurosis. The greatest single step in the prevention of emotional disorders would lie in dispelling the barbaric ignorance of parents as to when and how and at what rate to train children."

L. J. SAUL
The Bases of Human Behavior